HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

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IDPA USE ONLY

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME): Patient E
2. PATIENT'S DATE OF BIRTH: 051260
AGE
3. INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
TELEPHONE NO.:
5. PATIENT'S SEX: MALE ☐ FEMALE ☐
6. INSURED'S ID AND/OR MEDICARE NO. (INCLUDE ANY LETTERS)
7. PATIENT RELATION TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐
8. INSURED'S GROUP NO. (GROUP NAME) AND/OR MEDICAID NO.: 043626444
9. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER
10. WAS CONDITION RELATED TO
A. PATIENT'S EMPLOYMENT: YES ☐ NO ☐
B. ACCIDENT: AUTO ☐ OTHER ☐
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
SIGNED DATE
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM: YES ☐ NO ☐ CHECK HERE IF EMERGENCY ☐
17. DATE PATIENT ABLE TO RETURN TO WORK
18. DATES OF TOTAL DISABILITY FROM THROUGH
DATES OF PARTIAL DISABILITY FROM THROUGH
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
PROVIDER NUMBER
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE YES ☐ NO ☐ CHARGES:
23A. HEALTHY KIDS SERVICES YES ☐ NO ☐
23B. FAMILY PLANNING YES X NO ☐
23C. STERILIZATION/ABORTION YES ☐ NO ☐
23D. PRIOR AUTHORIZATION NUMBER
23E. T.O.S. * 1
23F. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

24. REPEAT	A. DATE OF SERVICE	B. P.O.S. *	C. BRIEFLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN — PROCEDURE CODE (IDENTIFY)	MOD		D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	DELETE
1	020205	3	A4267		MALE CONDOMS	PRIMARY V2540	20.00	0030	
2						SECONDARY			
3									
4									
5									
6									
7									

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE OF AND IS A PART OF THIS BILL)
ORIGINAL SIGNATURE REQUIRED
SIGNED DATE 020805
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY - SEE BACK) YES ☐ NO ☐
27. TOTAL CHARGE 20.00
28. AMOUNT PAID 0.00
29. BALANCE DUE 20.00
30. YOUR PROVIDER NUMBER 370624545001
31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE
PLANNED PARENTHOOD OF CITY
123 OAK STREET
ANYWHERE IL 60001
32. YOUR PATIENT'S ACCOUNT NUMBER Example 5
33. YOUR PAYEE NUMBER 1
34. NUMBER OF SECTIONS 1
35. ORIGINAL DCN
36. ORIGINAL VOUCHER NUMBER

37A. TPL CODE	37B. TPL STATUS	37C. TPL AMOUNT	37D. TPL DATE	38A. TPL CODE	38B. TPL STATUS	38C. TPL AMOUNT	38D. TPL DATE

* PLACE OF SERVICE (P.O.S.) AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment

Form Approved by the Forms Management Center

IL 478-1032
Form HCFA 1500
ILLINOIS DPA 2360 (R-2-90)